Frequently Asked Questions on IBHIS by Providers

DOCUMENT REVISION HISTORY		
Version	Release Date	Comments/Indicate questions added or answers revised.
1.1	01/15/2014	Initial version of the document compiled with the questions from 1 thru 29.

General Questions:

Q1: What is an Episode?

Ans: *For outpatient services there is one episode opened for a client at a Program of Admission, which associates 1:1 with the Legal Entity of our contract agencies. Directly Operated programs shared a single Program of Admission. Outpatient Fee for Service clients are all admitted to the same program of admission shared among all FFS2 practitioners.*

Please review to the Video presentation: 'Rethinking Outpatient Episodes – A Key Concept'

URL: http://file.lacounty.gov/dmh/cms1_204348.wmv

Q2: Is there only one Episode per client/Legal Entity for their lifetime or do LE's open and close programs as usual?

Ans: *Outpatient episodes stay open as long as the individual is alive, whether or not they are continuing to receive services from one of the Programs of Service operated by that Legal Entity.*

Mode 5 (inpatient/residential) episodes remain distinct, with a separate episode tied to each admission (inpatient facilities are Both Program of Admission and Program of Service).

Q3: What does the term "Program" means? It seems to refer to the Legal Entity in the Web Services Companion Guide, but also refer to as program service level in the Claims Companion Guide.

Ans: *The program referred in the Web Service is the Program of Admission and the program referred in the companion guide is the Program of Service.*

Please listen to the Video presentation: 'Rethinking Outpatient Episodes – A Key Concept'

Here is a URL: http://file.lacounty.gov/dmh/cms1_204348.wmv

Q4: Is the PFI equal to the first date they became a DMH client with the first agency and does this follow the client through a lifetime?

Ans: *The annual liability period is equal to the first date they become a DMH client with the first agency and it does follow the client year after year; however, if the client is not seen for several years, when they come back for services, the annual liability period would begin with the new admission date/initiation of services since the PFI has not been completed for the years that the client has not been seen.*

QX: With the concept of SFPR going away, how is the coordination of care managed across multiple LEs. What is the impact on cycle date?

Ans: *Coordination across LEs and episodes should be done according to appropriate clinical practice. However, at this time, there will be no paperwork required for coordination. In light of Healthcare Reform, we are waiting to determine whether new requirements for formal coordination arise. Current policy is being updated to state that each LE is responsible for its own cycle date for clinical paperwork.*

Q5: Is each CP/LE responsible for its own UMDAP dates?

Ans: *The client's annual charge period does not change when a client is open in different LEs at the same time. The initial UMDAP date will follow the client from provider to provider throughout the State. The only exception to this is when there is a significant lapse in service from any Mental Health Plan provider in California. Information regarding the responsible UMDAP provider is communicated throughout the system via the Systemwide Annual Liability fields in IBHIS.*

Q6: The program field references D.22 in the dictionary – these values include Reporting Unit numbers and we have a code for each site. How do RU numbers used with IBHIS relate to the IBHIS episode/admission?

Ans: *Episodes are opened to Admission program (ties to LE), while claims include taxonomy of the Service Program (ties to Reporting Units/Service Locations). The outpatient episode is created at the Program of Admission/Legal Entity level regardless of which Service Program within that Legal Entity initiates the episode.*

Q7: Dictionary Code Values vs IS Codes Manual. There are differences between these two documents. A few things noticed are: a) some field names have been changed so it's hard to compare, and b) some fields are new and not included in the IS Codes Manual. For example: Data Dictionary - "Service Type" and IS Codes Manual - "Program Area". These values look similar but are not identical. Customers are still relying on the IS Codes Manual because it's familiar, but may need to refer them only to the Data Dictionary going forward. Is this the right direction? Will the IS Codes manual be discontinued?

Ans: *Crosswalks between the IS values and IBHIS values have been provided. The IS Codes Manual will be discontinued once everyone is live on IBHIS. In its place, will be the data dictionaries provided for web services or the companion guide.*

Q8: What are the claim submission dates for Legal Entities?

***Ans**:* *1. Pilot 1 LE go-live 02/20/ 2014*

a) Dates of service prior to 02/08/2014 in IS
b) Dates of services on or after 02/08/2014 in IBHIS
(Claims with date of service 02/08/2013 must be held until they can be entered in to IBHIS beginning 02/20/2013)

2. Groups 3 – 5 go-live 07/01/2014

a) Dates of service for Fiscal Year 2013 – 2014 and prior in IS
b) Dates of services for Fiscal Year 2014 – 2015 and on in IBHIS

Note: There will be more information coming out toward the end of 2014 when the 'IS' is no longer available to the providers.

Q9: What are the claim submission dates for FFS Providers?

Ans: *1. FFS Pilot 1 Providers go-live Feb 20, 2014*

a) Dates of service prior to 01/01/2014 in IS.
b) Dates of service between 01/01/2014 to 02/19/2014 and submission date on or before 02/19/14 in IS.
c) Dates of service between 01/01/2014 to 02/19/2014 and submission after 02/19/14 in IBHIS.
d) Dates of Service on or after 02/20/14 in IBHIS.

2. All other FFS Providers go-live Sept 03, 2014.

a) Dates of service prior to 09/01/2014 in IS.
b) Dates of services on or after 09/01/2014 in IBHIS.

Note: There will be more information coming out toward the end of 2014 when the 'IS' is no longer available to the provider.

Q10: When will PATS be decommissioned? Will all PATS functionality be done on Order Connect?

Ans: *We will maintain PATS and IS portal into PATS for an extended period of time (likely into early 2015) for the continued support of the prescribing of medications to indigent clients where LACDMH pays the cost of the medication. Once live in IBHIS, contract agencies will be creating new IBHIS client records (if there is no existing PATID/client record already in the IBHIS) and IBHIS episodes. If these indigent clients and/or episodes do not already exist in the legacy Integrated System (IS), parallel "shadow" IS clients and/or episodes will need to be created to allow for the submission of PATS prescriptions. During this period, all prescriptions for which*

there is another payor (e.g., Medi-Cal) can be done outside of PATS and does not require any IS client/episode creation.

For DMH directly operated programs, PATS functionality will ultimately be replaced by a combination of OrderConnect (ePrescribing) and a Pharmacy Benefits Manager for indigent client (PBM for formulary management, claims adjudication, etc). Once a PBM is implemented, pharmacies dispensing medications for indigent clients prescribed by an LACDMH contracted agency will leverage the PBM service in lieu of PATS to determine eligibility. More information will be provided at a future date regarding actions required of contract agencies for assuring indigent clients inclusion in the eligibility file. Contracted agencies will NOT have access to OrderConnect for ePrescribing. If contract agencies plan to use ePrescribing (including to help obtain Meaningful Use incentive payments) they will need to obtain their own eRx solution.

Q11: Where can we obtain AID codes for Medical Programs, i.e. extended Medical and Katie A Medical?

Ans: *The most recent Aid Code bulletin as of October 28, 2013 can be found at <Click Here>*

Or use this actual URL Address: http://file.lacounty.gov/dmh/cms1_204971.pdf.

However, always check the RMD Bulletins website <Click Here>
Or use this path for access

http://dmh.lacounty.gov

- *Click the link 'For Providers' on the top bar*
- *Click the 'Administrative Tools' from the side bar*
- *Click 'Revenue Management Division Bulletins' from the right side 'Bulletin' Section to see if a more recent bulletin has been published.*

Q12: Since the concept of SFPR is going away, our understanding is:

a. No single agency is responsible for coordinating services with agencies across LA County

b. If service occurs for out of county clients LA County agencies are no longer responsible for approving services

c. Each agency is responsible for creating, signing, and managing assessments and CCCPs without approval or signature from other agencies

Is this correct??

Ans: *Yes that is correct.*

Q13: Provider Treatment Plan & DMH print view. Can we get written approval to replace the CCCP with Providers print view of the treatment plan?

Ans: *As long as the Providers print view has the data elements noted in the Organizational Provider's Manual page 1-11 (http://file.lacounty.gov/dmh/cms1_159846.pdf) then it is approved. Unfortunately, we will not be*

able to look at every Providers print view to verify/approve it. It is up to the Provider to ensure it has the required data elements of a treatment plan.

ProviderConnect:

Q14: ProviderConnect will be used for P-Authorizations?

Ans: *No, P-Authorizations are essentially the authorization numbers tied to budgeted maximum contract amounts by funding source for the entire fiscal year – thus they are determined by the contract and do not require separate requests by the provider and they are not tied prospectively to specific clients. It will be created centrally at DMH and will be distributed via LE Extract/SIFT or some other mechanism. Further information will be shared when this is ultimately determined. There are some other functions that will be leveraging ProviderConnect that are specific to our Fee For Service providers.*

Q15: ProviderConnect will be used for M-Authorizations?

Ans: *Yes, providers will use ProviderConnect for requesting Member Authorizations and receiving the response to the request.*

Q16: Is there any connection between LE Extracts/EFT(SIFT) and ProviderConnect? Agencies will still need LE Extract/EFT(SIFT) for certain reporting functions.

Ans: *There is no connection between them. Agencies will have reports in their EFT folder.*

Practitioner Maintenance Application

Q17: Does the Information entered in practitioner maintenance application need to match information on claims coming from provider?

Ans: *Yes*

Q18: There isn't any provider/practitioner information exchanged through web services, correct?

Ans: *Correct*

Q19: What criteria will DMH use to establish whether or not a client is active in a particular LE if we are not discharging an episode until the client is deceased?

Ans: *Service (claim) data will be used to determine whether the client is active or not in a particular program.*

Q20: How does a LE/Program release liability when a client is no longer under our care if the episode remains open (Some Providers we have an LE/agency level admit/discharge which is similar to IBHIS single episode, but we also admit/discharge within Programs and Services layers but this info does not appear to be exchanged thru web services)?

Ans: *This is a legal issue to discuss with your own legal counsel. For Directly Operated programs, an episode being open or closed is generally not considered a significant determinant of liability. Clinical service delivery and the documentation of those services is typically a primary consideration regarding liability.*

Client Signatures

Q21: With more data collected in the EHR and exchanged thru web services to IBHIS, how will that impact the need for client signatures? For example many fields from the PFI are now required in the EHR. Does this mean the requirement for the current PFI form will be eliminated, and if so, also the need for a client signature on this data?

Ans: *A client's signature is still required for the financial screening process/PFI. The signature can, for example, be captured on paper and retained in the EHR via scanning as long as it is available for review in case of audit. Also, a copy of the PFI should be given to the client for their records.*

Data Mapping & Population

Q22: What client information is considered during the initial conversion of IS to IBHIS?

Ans: *The conversion of client data from the IS into IBHIS is a relatively complex, one-time process that involved multiple intermediate steps associated with tasks including DMH medical records review to de-duplicate clients with multiple existing IS numbers, algorithms to "roll-up" existing IS episodes (at the reporting unit level) to the new IBHIS episode structure (at the Program of Admission/Legal Entity level). The original pull for this data was in late August 2013, and that dataset went through a rigorous de-duplication process. New IS client records created between then and December 18, 2013 were appended to that dataset and form the core of the client conversion dataset. The episodes of clients who had an open outpatient episode within a service location as of December 18, and who had been seen within that episode since 7/1/13 were included as episodes that were part of the rollup for new IBHIS episode creation. There were also algorithms that selected from among those included episode which diagnosis would be converted to the new IBHIS episode.*

Q23: What client information will be pushed from IS to IBHIS, and how long will we need to track changes to client information to update the data gap between what was pushed and what was not?

Ans*: The IS push will involve processes run in DMH data warehouse comparing existing IBHIS client records against new IS client records created since December 18, 2013, and pushing only those client records that appear non-duplicative. DMH expects to do an initial update sometime in February, then likely a daily process thereafter. The push will only create a new client record and an initial IBHIS episode (at the Admission Program/Legal Entity level) based on the initial IS episode created for that new client. If the client information is already converted to IBHIS and new episodes are created for that client in IS, or if existing client/episode data is updated in IS, those updates will NOT be pushed to IBHIS. IBHIS client and diagnostic information should be verified once and updated (if necessary) once live in IBHIS.*

Q24: What data elements are being pushed from IS to IBHIS post-conversion?

***Ans**: Initial configuration of the Push includes the following elements. This may expand.*

Episode Information	Diagnosis Related information:
ClientID,	ClientID
Client First Name	episodeID
Client Last Name	DiagnosisDate
episodeProgram	DiagnosisTime
episodeAdmissionDate	DiagnosisType
episodeAdmissionTime	DiagnosisingStaffID
episodeAdmissionType	DiagnosisPrincipal
episodeAdmissionStaffID	DiagnosisAxisI
ClientGender	DiagnosisAxis1_2
ClientDateOfBirth	DiagnosisAxis1_3
ClientSocialSecurityNumber	DiagnosisAxisII_1
ClientLivingArrangement	DiagnosisAxisIII_1
ClientStreetAddress1	DiagnosisTrauma
ClientStreetAddress2	DiagnosisGeneralMedicalSummaryCd
ClientAddressZip	DiagnosisSubstanceAbuseDependence
ClientCity	DiagnosisSubstanceAbuseDependenceDiagnosis
ClientState	
ClientHomePhoneNumber	
ClientMaritalStatus	
ClientPrimaryLanguage	
ClientRace	
ClientEthnicOrigin	
ClientEducation	
ClientEmploymentStatus	
ClientAlias	

Q25: When we do get the EFT report (extract) that we are to reconcile against? Does this contains provider clinics data only (episode), or is this all client data (ie shared demographics that could come from another agency).

***Ans:** An EFT report will be provided after the conversion is completed with the client and diagnostic information in IBHIS. This will include client information for all clients who had an IBHIS episode created within their admission program (Legal Entity) via the conversion routine (clients with open IS episodes as of Dec 18, 2013 with at least one service subsequent to 7/1/13). Due to client de-duplication, and episode structure rollup, the demographic & diagnostic information converted was based on survivor record algorithms and, in some instances LACDMH Medical Records staff review. Target for initial EFT file is February 2014. We will also supply a list of patient Id's in instances where the IS ids you are currently using was rolled into a different 'Surviving' ID. Subsequent reconciliation datasets may include IS Push created records.*

Q26: Will diagnosis information be provided for review, and if so, when and in what format?

Ans: *Yes, via EFT file in Excel spreadsheet or Access database (tbd). Target is February 2014.*

Q27: When an agency goes live with web services, will there be an option on all required fields of unknown or something the Provider can default for those fields?

Ans: *There may be new fields that agencies don't currently capture in their EHRs. Going forward, agencies are modifying their workflow processes to collect and document the data. Ultimately, agencies are responsible for assuring the completeness and accuracy of all data submitted via webservices for clients to whom they are actively providing services.*

Q28: Is there a crosswalk exist between current IS Plans and IBHIS Funding Source?

Ans*: Currently being developed.*

Q29: Where do I find out more information about claims and web-services?

Ans: *The companion guide documents are available in the below URL.*
URL: http://lacdmh.lacounty.gov/hipaa/IBHIS_EDI_Guides.htm